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ABSTRACT

Substitute care for a child at risk has been been associated with psychological distress in the child and his family and a drain on public finances. To investigate the cost effectiveness and ultimate influence on family intactness of home-based family crisis intervention, 77 low income, inner city families with an adolescent child at risk of placement into formal substitute care participated in a family intervention program for 8 to 10 weeks under one of three treatment modes: in home crisis intervention (IHC); IHC combined with didactic skill training; and IHC combined with a network approach. IHC is a generic brief therapy emphasizing structural family therapy, building parenting skills, exploring problem solving approaches, and improving family interaction patterns. Skill training involved communication, self-care, and stress management. The network mode helped families coordinate their existing support systems or helped them build support systems. Demographic, pre-post therapy information, and follow-up data were collected on all participants. An analysis of the results showed that at termination of treatment 88 percent of the families were intact, representing a savings of one half million dollars in public funds. The IHC network approach was most effective, accounting for the smallest percentage of out-of-home placements. However, the network approach was the most difficult to implement due to the threatening nature of outside involvement and the lack of counselor control over the client and his network. (BL)

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HOME-BASED CRISIS THERAPY:

A COMPARATIVE OUTCOME STUDY

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HOME-BASED FAMILY CRISIS THERAPY: A COMPARATIVE OUTCOME STUDY

Introduction

The reported research constitutes the final evaluation of an NIMH-funded clinical research project that investigated the relative efficacy of three types of home-based crisis intervention for families with a child at risk of placement into substitute care. A number of approaches to crisis intervention with high-risk families have proven effective. Projects such as the Homebuilders Project in Tacoma, WA have shown that home-based crisis intervention is a particularly cost-effective procedure for helping families as contrasted to the removal of a child from the family home. Substitute care arrangements are known to be associated with significant psychological distress in children as well as a drain on public finances. What has been lacking is a systematic comparison of different types of home-based interventions in terms of their cost-effectiveness and their ultimate influence on family intactness. Three treatment modes were examined by this project. They were a generic In-Home Crisis Intervention (hereafter labelled IHC): IHC combined with didactic Skill-Training sessions; and IHC combined with a Network approach. Project staff included family therapists who provided all clinical services and research staff who collected and analyzed data.

Method

Subjects

Subjects were families with a child at risk of placement into formal substitute care, most of whom were referred by the local Children's Services Division. Families were predominantly single-mother families or blended (step) families. Many families (39%) lived below the poverty level and a disproportionate number of families included a mother who had been a teenage parent (48%). Two-thirds of the focal children were between the ages of 10 and 19 years, with a mean age of 12 years. There were an equal number of male and female focal children and 22% belonged to ethnic minorities. 41% of the children had suffered physical and/or sexual abuse. The families came from a low-income inner city area and they represent a typical high-risk, multiproblem sample from such a population. 77 families make up the sample.

Clinical Methods

Table 1 outlines characteristics of the three treatment modes offered. Common characteristics across all modes include the following. All services were offered free of charge in exchange for provision of research data. All services were provided in clients' homes or at meeting places in the clients' neighborhoods (such as the child's school or the parents' workplace). Services were intensive (1 or more 2-hour sessions per week with phone contact in between), and therapists were available on a 24-hour basis for crisis management. Participation by the entire family was the ideal but was not required. Intake and termination sessions involved both clinical and research staff. Pre and post assessment instruments were administered at these sessions. In between, research staff collected data independently

during the very brief(8 to 10)week clinical involvement. Clients were assigned to a treatment by systematically rotating through the three treatment modes so that the treatment assignment was predetermined at the point of referral.

The bottom of Table 1 lists major components of the three modes and the *n* for each. IHC was a generic brief therapy emphasizing structural family therapy, building parenting skills, exploring problem-solving approaches, and improving family interaction patterns. The Skill Training mode involved IHC combined with didactic skill training sessions in specific areas of family and individual functioning such as communication, self-care and stress management. Skill topics were elected by the clients, and generally only parents were involved. The Network mode involved the IHC combined with an effort to help families coordinate their existing support systems or to help them build social support systems. The purposes of Networking are to reduce stresses between family members and their personal or collective networks and to engage the network to help the family to identify and solve current and future problems.

Data Systems

Table 2 outlines the project's data systems. A variety of measures of total family functioning and focal child behavior were collected during and following treatment of families. All data were collected by research staff, with researchers and clinicians often coordinating visits with reluctant families in order to assure cooperation with data collection requirements. It was difficult to find standardized instruments that would serve for the highly variable subject population. Families differed widely in terms of SES, literacy, and cultural background, while focal children ranged in age from a few months to 19 years. Therefore, a number of instruments were developed by the project. As you can see, we collected demographic data which included network information and a variety of pre-post therapy instruments which were administered to parents and focal children. Follow-up data included feedback from clients (anonymously provided), feedback from therapists, and regular telephone interviews following termination. Although parental self-report data were collected from both parent-figures whenever possible, very few cases involved a father figure.

Results

Overall Efficacy of Home-based Treatment

The major goal of all three treatment modes was to prevent the placement of focal children into substitute care. Thus, the most critical piece of data was the rate of placement of children subsequent to intake. Placement was defined as any formal substitute care arrangement outside of the natural family system. A minimum of three months of follow-up data is available on all families, while the total follow-up ranges from case to case, depending upon date of intake. Table 3 displays the proportion of intact families at each follow-up point from termination to 21 months post-termination. The number in parentheses at the top of each column indicates the number of

families represented at each point. At termination, 88% of families were intact. Family intactness rates ranged thereafter from 71% to 90%. These intactness rates are comparable to those of other home-based crisis programs. An estimated savings of $575,141 in public funds for substitute care was achieved by the prevention of placement across those subjects who remained in the home.

Treatment Mode Differences

Now for a look at differences between treatment groups. It is difficult to compare outcome data from a selection of cases for which different periods of follow-up data are available and where focal children may be temporarily placed and then returned home. A dichotomous measure of placement versus nonplacement at an arbitrarily chosen follow-up point ignores important aspects of the data. In cases where placement is not completely averted, the intervention may yet affect the duration of placement, and this effect is potentially different for different treatment modes. Thus it is desirable to account for both number of follow-up months and the actual number of placement months per family in any between-group comparisons. Table 4 displays the total number of placement months, total number of intact months (or non-placement months) and total number of follow-up months for each treatment group. These are computed on a family-by-family basis. Therefore, a family who was followed for 12 months post-termination with a focal child who was in placement for 4 months would contribute 12 follow-up months, 4 placement months and 8 intact months to the group total. As you can see, the Network group suffered relatively few placement months.

From the figures in Table 4, a "placement proportion" was calculated for each treatment group, as well as its reciprocal, the "intactness proportion". These proportions appear in Table 5. The placement proportion is the proportion of placement months out of total follow-up months for each group. IHC and Skill Training groups yielded placement proportions of .28 and .26 respectively, while the placement proportion for the Network group was only .12. A chi-square on the contingency table created by the group variable and placement versus intact months is significant at the .001 level, indicating a strong relationship between treatment mode and intactness. A comparison of the placement proportion of the Network group versus the mean placement proportion for the other two groups yields a Z-score significant at the .000 level. Clearly, the Network group fared significantly better than IHC or Skill Training groups in terms of averting placements.

Discussion

The effectiveness of the Network approach is at first blush not surprising. A successful network intervention should leave the family well-connected with ongoing support systems after therapy has terminated. Both family and network members are made aware of the current family problems and the potential for future problems, and they are left with a plan for coping with future problems. Thus, if a crisis does arise post-therapy,

the family should be more likely to resolve the problem without resorting to external intervention. For all its virtues, however, the Network mode was by far the most difficult to implement. Many of the project's clients were resistant to any sort of therapy at all, and the prospect of involving persons outside the family was simply an additional threat. The brief duration of treatment was a particular problem in this mode since more time is generally required to overcome the client's fears and resistance to involving others in their problems. These difficulties are underscored by the therapists' own ratings of their success in implementing the assigned treatment mode which they rated at the termination of each case. Therapists rated their success significantly lower for the Network group than for IHC or Skill Training groups. The therapists' discomfort with the Network mode may reflect the relative lack of therapist control which is an important aspect of Networking. Networking tends to minimize the therapists' control while it maximizes the clients' control. The therapist must rely heavily upon clients to reveal information about their networks and to schedule network meetings. The client is the expert on his/her network, not the therapist.

Conclusions

In conclusion, the current emphasis on helping families by examining and altering processes internal to the family may need to be balanced by approaches that help therapists to understand the relationship of the family to its immediate and larger community. To accomplish this, more information is needed on family networks and community connectedness in general as well as an understanding of the effects of support networks on families. We need to define the characteristics of networks that are positively reflected in family functioning and to define minimal levels of support necessary for particular high risk groups. Finally, research is necessary to determine what types of training help therapists to most effectively and comfortably promote family support systems.

Table 1. TREATMENT MODES

Characteristics Common to All Treatment Modes

1. Services free in exchange for provision of data.
2. All sessions (therapy & data) held in clients' homes or neighborhoods.
3. Intensive services: face-to-face and phone contact as needed.
4. 24-hour therapist availability for crisis situations.
5. Participation of entire family encouraged but not required.
6. Duration of services: 8-10 weeks.
7. Intake & termination sessions involved research & clinical staff.
8. Research staff collect data independently throughout therapy.
9. Follow-up data gathered every 3 mo. by research staff.

	Treatment Mode	Major Components	n (# families)
I.	IHC (In-Home Crisis Therapy)	Structural family therapy. Problem-solving approaches. Shifting focus from focal child. Emphasis on family strengths.	26
II.	IHC + Skill Training	All IHC components + Four separate skill-training sessions. One topic per session. Parents only.	26
III.	IHC + Networking	All IHC components + Gathering of network data. Network planning activities. Network meeting(s)	25

Table 2. DATA SYSTEMS

Demgraphic Data

Intake form.

Presenting Problem Checklist

Support Network Form

Pre-Post Therapy Measures

MOOS Family Environment Scale (Abbreviated Version)

Piers-Harris Scale

Family Event List

Family Activities List

Achenbach Child Behavior Checklist

Child Disruptive Behavior Checklist

Child Attitude Survey

Community Interaction Interview

Follow-up Data

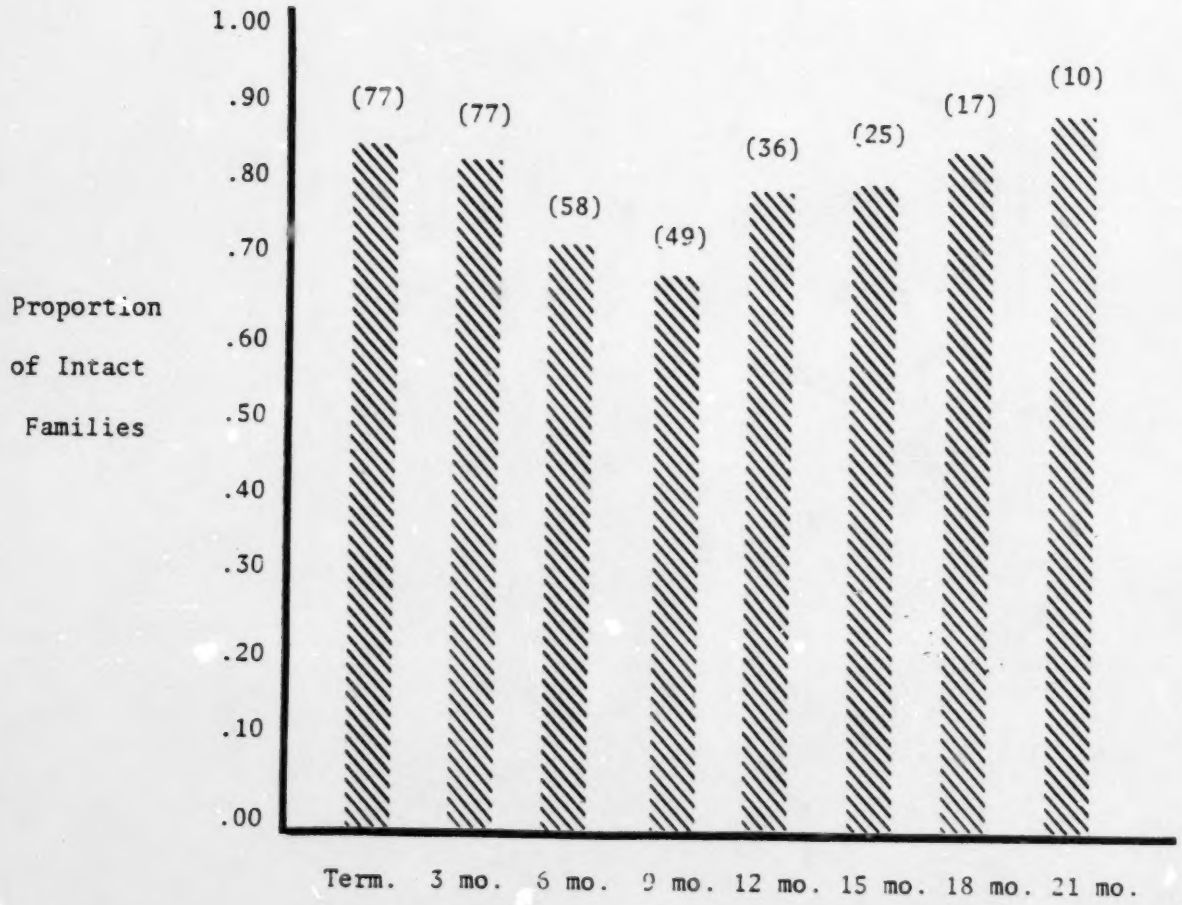
Consumer Satisfaction Form

Therapist Satisfaction Form

Follow-up Interview

All data gathered by research staff.

Table 3. Proportion of Intact Cases by Follow-up Point



(Figures in parentheses indicate number of families represented at each data point.)

Table 4. Placement Data by Treatment Group

	IHC	Skill Training	Network
Total # Placement Months (a)	77	74	28
Total # Intact Months (b)	199	208	227
Total # Follow-up Months (c)	276	282	255

Table 5. Placement Proportion by Treatment Group

	IHC	Skill Training	Network
Placement Proportion (a/c)	.28	.26	.12
Intactness Proportion (b/c)	.72	.74	.88